UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

October 2012 Grand Jury

UNITED STATES OF AMERICA, Plaintiff, v. VALERY BOGOMOLNY, Defendant.	CR No. CR13-0666 I N D I C T M E N T [18 U.S.C. § 1347: Health Care Fraud; 18 U.S.C. § 2(b): Causing an Act to be Done]

The Grand Jury charges:

COUNTS ONE THROUGH SIX

[18 U.S.C. §§ 1347 and 2(b)]

A. INTRODUCTORY ALLEGATIONS

1. Between in or around November 1994 and in or around October 2009, defendant VALERY BOGOMOLNY ("BOGOMOLNY") was the Owner and President of Royal Medical Supply ("Royal"), a supplier of durable medical equipment ("DME"), primarily back braces, knee braces, and power wheelchairs ("PWCs"), located in Los Angeles, California, within the Central District of California.

2. On or about December 8, 1994, defendant BOGOMOLNY executed and submitted an application to Medicare to obtain a Medicare provider number for Royal.

3. In or around 1997, defendant BOGOMOLNY opened a corporate bank account for Royal at Citibank, account number xxxx6974 (the "Royal Bank Account"). Defendant BOGOMOLNY maintained primary control of this account.

4. On or about March 15, 2007, defendant BOGOMOLNY executed and submitted an electronic funds transfer agreement ("EFT") to Medicare requesting that all future reimbursements from Medicare be directly deposited into the Royal Bank Account.

5. Between on or about January 1, 2006, and on or about October 28, 2009, Royal submitted to Medicare claims totaling approximately $4,074,490 for DME, primarily back braces, knee braces, and PWCs, and Medicare paid Royal approximately $2,742,328 on those claims.

The Medicare Program

At all times relevant to this Indictment:

6. Medicare was a federal health care benefit program, affecting commerce, that provided benefits to individuals who were over the age of 65 or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services ("HHS").

7. CMS contracted with private insurance companies to (a) certify DME providers for participation in the Medicare program and monitor their compliance with Medicare standards; (b) process

and pay claims; and (c) perform program safeguard functions, such as identifying and reviewing suspect claims.

8. Individuals who qualified for Medicare benefits were referred to as Medicare "beneficiaries." Each Medicare beneficiary was given a Health Identification Card containing a unique identification number ("HICN").

9. DME companies, physicians, and other health care providers that provided medical services that were reimbursed by Medicare were referred to as Medicare "providers."

10. To obtain payment from Medicare, a DME company first had to apply for and obtain a provider number. By signing the provider application, the DME company agreed to abide by Medicare rules and regulations, including the Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)), which, among other things, prohibits the payment of kickbacks or bribes for the referral of Medicare beneficiaries for any item or service for which payment may be made by Medicare.

11. If Medicare approved a DME company's application, Medicare would assign the provider a Medicare provider number, enabling the DME company to submit claims to Medicare for services and supplies provided to Medicare beneficiaries.

12. To obtain and maintain their Medicare provider number billing privileges, DME suppliers had to meet Medicare standards for participation. The Medicare contractor responsible for evaluating and certifying DME providers' compliance with these standards was Palmetto GBA ("Palmetto").

13. From in or about October 2006 through the date of this

Indictment, Noridian Administrative Services ("Noridian") processed and paid Medicare DME claims in Southern California.

14. To bill Medicare for DME it provided to a beneficiary, a DME provider was required to submit a claim (Form 1500). Medicare required claims to be truthful, complete, and not misleading. In addition, when a claim was submitted, the provider was required to certify that the services or supplies covered by the claim were medically necessary.

15. Most DME providers, including Royal, submitted their claims electronically pursuant to an agreement with Medicare that they would submit claims that were accurate, complete, and truthful.

16. Medicare required a claim for payment to set forth, among other things, the beneficiary's name and HICN, the type of DME provided to the beneficiary, the date the DME was provided, and the name and unique physician identification number ("UPIN") or national provider identifier ("NPI") of the physician who prescribed or ordered the DME.

17. Medicare paid DME providers only for DME that was medically necessary to the treatment of a beneficiary's illness or injury, was prescribed by a beneficiary's physician, and was provided in accordance with Medicare regulations and guidelines that governed whether a particular item or service would be paid by Medicare.

B. THE SCHEME TO DEFRAUD

18. Beginning on or about January 1, 2006, and continuing through in or around October 2009, in Los Angeles County, within the Central District of California, and elsewhere, defendant

BOGOMOLNY, together with others known and unknown to the Grand Jury, knowingly, willfully, and with intent to defraud, executed, and attempted to execute, a scheme and artifice: (a) to defraud a health care benefit program, namely Medicare, as to material matters in connection with the delivery of and payment for health care benefits, items, and services; and (b) to obtain money from Medicare by means of material false and fraudulent pretenses and representations and the concealment of material facts in connection with the delivery of and payment for health care benefits, items, and services.

C. MEANS TO ACCOMPLISH THE SCHEME TO DEFRAUD

19. The fraudulent scheme operated, in substance, as follows:

a. Defendant BOGOMOLNY obtained Medicare beneficiary information through various means for the purpose of using that information to submit, and cause the submission of, claims to Medicare on behalf of Royal. These claims were for DME that was not medically necessary and at times was not provided to the beneficiaries.

b. Defendant BOGOMOLNY obtained prescriptions for DME, primarily back braces, knee braces, and PWCs, purportedly ordered by doctors. These doctors were not the primary care physicians for the beneficiaries, and some of the doctors did not know that their provider numbers were being used to prescribe DME.

c. Defendant BOGOMOLNY delivered, or caused to be delivered, DME to some of the Medicare beneficiaries, knowing that those beneficiaries did not medically need the DME. For

other beneficiaries, defendant BOGOMOLNY either failed to deliver any DME or delivered only a portion of the DME for which Royal billed Medicare.

d. Defendant BOGOMOLNY created false and fraudulent documentation to support Royal's purported delivery of DME to beneficiaries, even though, as defendant BOGOMOLNY then well knew, some of the beneficiaries did not receive any DME or received only a portion of the DME that was documented in the patient files.

e. Defendant BOGOMOLNY then submitted, and caused the submission of, false and fraudulent claims to Medicare for DME, including back braces, knee braces, and PWCs, that Royal purportedly provided to Medicare beneficiaries, knowing that the beneficiaries did not have a medical need for the DME and that some beneficiaries did not receive the DME for which Royal billed Medicare.

f. As a result of the submission of false and fraudulent claims, Medicare made payments to the Royal Bank Account, which defendant BOGOMOLNY controlled.

g. Defendant BOGOMOLNY then transferred and disbursed monies from the Royal Bank Account to himself and others, and withdrew large amounts of money in cash.

D. THE EXECUTIONS OF THE FRAUDULENT SCHEME

20. On or about the dates set forth below, within the Central District of California and elsewhere, defendant BOGOMOLNY, together with others known and unknown to the Grand Jury, for the purpose of executing and attempting to execute the fraudulent scheme described above, knowingly and willfully caused

to be submitted to Medicare for payment the following false and fraudulent claims purportedly for DME:

COUNT	BENEFICIARY	CLAIM NUMBER	DATED CLAIM SUBMITTED	AMOUNT CLAIMED
ONE	M.R.	109021804534000	1/21/2009	$2,233.00
TWO	A.C.	109021804525000	1/21/2009	$5,640.00
THREE	M.H.	109035818011000	2/04/2009	$5,865.00
FOUR	S.G.	109083852400000	3/24/2009	$5,765.00
FIVE	S.P	109128839675000	5/8/2009	$1,300.00

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COUNT	BENEFICIARY	CLAIM NUMBER	DATED CLAIM SUBMITTED	AMOUNT CLAIMED
SIX	K.B.	109212831225000	7/31/2009	$974.00

A TRUE BILL

/S/

Foreperson

ANDRÉ BIROTTE JR.
United States Attorney

ROBERT E. DUGDALE
Assistant United States Attorney
Chief, Criminal Division

RICHARD E. ROBINSON
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